

# Screening Guidelines

Healthcare providers assume responsibility for comprehensive breast and cervical cancer, cardiovascular, and diabetes screening services and must:

- ⊙ Have a medical supervisor/director to ensure that healthcare providers are competent and proficient in clinical screening services and related patient education and counseling and to ensure that professional credentials are current.
- ⊙ Provide pelvic examination, in conjunction with a Pap test and clinical breast examination by a healthcare provider and referral for screening and/or diagnostic mammogram as indicated per screening guidelines.
- ⊙ Provide and participate in patient education activities with assistance from EWM as needed or requested. The education/counseling includes: breast self-examination instruction, screening guidelines, risk factor information, recommendations for positive lifestyle changes and counseling on abnormal findings and necessary follow up.
- ⊙ Utilize laboratories and refer enrolled clients for mammography and breast ultrasound to an approved Referral Provider.
- ⊙ Provide or refer for colposcopy and colposcopy-directed biopsy of cervical lesions. These services shall be provided by a healthcare provider who has received specialized training in colposcopy and/or colposcopy-directed biopsy. Healthcare providers must refer enrolled clients to an approved Referral Provider.
- ⊙ Provide or refer for diagnosis and treatment of high-grade lesions to an OB/GYN.
- ⊙ Provide or refer for fine needle or cyst aspiration of palpable breast lumps or breast lesions apparent on mammography. These services shall be provided by an approved, licensed healthcare provider who has received specialized training in breast fine needle and/or cyst aspiration. Healthcare providers must refer enrolled clients to an approved Referral Provider.
- ⊙ Provide cardiovascular and diabetes screening as described in the Screening Guidelines Section. Discuss and advise clients with elevated cholesterol, blood pressure, blood glucose, or body mass index, based on their lab values, on strategies to reduce their risk factors and attain healthiest screening outcomes. See Cardiovascular Screening Protocols Section.

- Computer Aided Detection (CAD) is **NOT** reimbursable.
- Magnetic Resonance Imaging (MRI) is **NOT** reimbursable.

Who Can You Enroll & What Screening and Diagnostic Services Can They Receive?			
ENROLLMENT	SCREENING SERVICES	DIAGNOSTIC SERVICES	ADDITIONAL SERVICES
Who can be enrolled?	What screening services are available?	What diagnostic service can they receive?	After client is enrolled, what additional follow up services is she eligible for?
<p>Women 18 through 39 years of age who have a palpable breast mass suspicious for malignancy</p> <p><b>*EWM highly encourages every client with a suspicious breast mass to be referred to a surgeon. The CDC recommends that every client 18 years of age and older with a suspicious clinical breast exam be referred to a surgeon.</b></p>	<ul style="list-style-type: none"> <li>NONE</li> </ul>	<ul style="list-style-type: none"> <li>Surgeon may order imaging after consultation</li> <li>Breast Ultrasound (<b>Must be preauthorized</b>) <i>*Reimbursement for breast ultrasound needs to be preauthorized for clients 18-39, except when recommended by a radiologist following a diagnostic mammogram in clients 30-39. Approval is based on funding availability.</i></li> <li>Diagnostic Mammogram (<b>Client must be at least 30</b>)</li> <li>Fine Needle/Cyst Aspiration</li> <li>Ultrasound Guided Fine Needle/Cyst Aspiration</li> <li>Repeat Breast Exam</li> <li>Biopsy:               <ul style="list-style-type: none"> <li>Needle Core w/ or w/out imaging</li> <li>Mamotome</li> <li>Open Incision/ABBI w/ or w/out imaging</li> <li>Excision w/ or w/out imaging</li> </ul> </li> <li>For cervical diagnostic services see the Cervical Diagnostic Enrollment/Follow Up and Treatment Plan (Section 2, Page 3) (example of this form located in the Forms &amp; Materials Section on Page 11-4)</li> </ul>	<ul style="list-style-type: none"> <li>NONE</li> </ul>
<p>Women 40 and above not covered by Medicare Part B</p>	<ul style="list-style-type: none"> <li>Pap Test biennially (every 2 years)</li> <li>Pelvic Exam in conjunction with clinical breast exam and/or Pap test</li> <li>Clinical Breast Exam (CBE)</li> <li>Teaching of Breast Self-Exam (BSE)</li> <li>Screening Mammography</li> <li>Blood Pressure according to guidelines</li> <li>Height, Weight and Waist Circumference according to guidelines</li> <li>Fasting lipids to include total cholesterol and HDL according to guidelines</li> <li>Fasting glucose according to guidelines</li> <li>A1c if previously diagnosed with diabetes according to guidelines</li> </ul> <p>(Services available according to screening services listed on Screening Visit Card)</p>	<ul style="list-style-type: none"> <li>Breast Ultrasound</li> <li>Diagnostic Mammography -Compression, Magnification, Additional Views, etc.</li> <li>Fine Needle/Cyst Aspiration</li> <li>Ultrasound Guided Fine Needle/Cyst Aspiration</li> <li>Repeat Breast Exam</li> <li>Biopsy:               <ul style="list-style-type: none"> <li>Needle Core w/ or w/out imaging</li> <li>Mamotome</li> <li>Open Incision/ABBI w/ or w/out imaging</li> <li>Excision w/ or w/out imaging</li> </ul> </li> <li>For cervical diagnostic services see the Cervical Diagnostic Enrollment/Follow Up and Treatment Plan (Section 2, Pg 3) (example of this form located in the Forms &amp; Materials Section on Page 11-4)</li> </ul>	<ul style="list-style-type: none"> <li>Follow up Pap test according to the 2006 ASCCP guidelines and with pre-authorization after abnormal Pap test/Colposcopy</li> <li>Follow up CBE</li> <li>Follow up Ultrasound</li> <li>Follow up Mammography</li> </ul> <p><b>NOTE:</b> If 2006 ASCCP Guidelines indicate cytology at 6 months and 12 months or HPV testing at 12 months, EWM will <b>ONLY</b> pay for HPV testing at <b>12 months</b>.</p>

Screening Visit		
Clients 18-39 ( <i>ENROLLED PRIOR TO JULY 1, 1997</i> )		
Exams Clients Should Receive:	Paperwork the healthcare provider completes:	What you give the client:
1. Clinical Breast Exam 2. Teach/Review Breast Self Exam 3. Pelvic Exam * 4. Screening Pap test biennially (every 2 years)	1. EWM Screening Visit Card that the client brought with her. 2. Affix the Red and White sticker to the lab requisition for the Pap test evaluation so the lab will bill EWM.  For clinics using electronic submission of lab requisition indicate EWM for billing purposes.  Example Sticker: <div style="border: 1px solid black; padding: 10px; text-align: center;"> <b>Every Woman Matters</b>  <b>1-800-532-2227</b> </div> <i>(Example of Screening Visit Card located on page 3-5)</i>	1. No paperwork given to client at this time.
<p>* Pelvic exam must be in conjunction with a Pap test and/or clinical breast exam in order to be reimbursed.</p> <p><b>NOTE:</b> Clients enrolled prior to July 1, 1997, will be issued Screening Visit Cards by EWM. No new client under 40 can be enrolled for screening. (<i>See Breast or Cervical Diagnostic Enrollment Guidelines on pages 2-2 through 2-4 for enrollment for diagnostic services</i>)</p> <p><b>NOTE:</b> Screening mammography is not reimbursable for clients under the age of 40.</p>		

# Example of form for Screening Visit for Clients 18-39 (enrolled prior to July 1997)

## Screening Visit Card

NOTE: Take this card to your appointment. Use within 3 months after receiving. This Screening Visit Card may have an expiration date on the label.

**Steps to Take Now that You Received Your Screening Visit Card:**

- Call to make an appointment. Tell the clinic you have an EWM Program Screening Visit Card when you set a time for your visit.
- Be sure to read the Client Information Booklet that arrived with your Screening Visit Card. It is very important that you read this booklet before you go to your appointment.

### Health Assessment

Please answer the questions below before you see your healthcare provider. Your response helps us and our partners plan for future programs, education, and information related to good health.

Have you ever been told by a doctor, nurse, or other health professional that your blood cholesterol is high? ☐ Yes ☐ No ☐ Don't know

Have you ever been told by a doctor, nurse, or other health professional that you have high blood pressure? ☐ Yes ☐ No ☐ Don't know

Have you ever been told by a doctor, nurse, or other health professional that you have diabetes? ☐ Yes ☐ No ☐ Don't know

Has your doctor, nurse, or other health professional ever told you that you had any of the following: heart attack, stroke, chest pain, heart failure, angina, coronary heart disease, or stroke? ☐ Yes ☐ No ☐ Don't know

Has your father, brother, or son had a stroke or heart attack before age 65? ☐ Yes ☐ No ☐ Don't know

Has your mother, sister, or daughter had a stroke or heart attack before age 65? ☐ Yes ☐ No ☐ Don't know

Has either of your parents, your brother or sister, or your child ever been told by a doctor, nurse, or other health professional that he or she has diabetes? ☐ Yes ☐ No ☐ Don't know

Are you currently taking medication for high cholesterol? ☐ Yes ☐ No ☐ Don't know

Are you currently taking medication for high blood pressure? ☐ Yes ☐ No ☐ Don't know

Are you currently taking medication for diabetes? ☐ Yes ☐ No ☐ Don't know

Do you ever smoke cigarettes? ☐ Yes ☐ No ☐ Don't know

**Fruits and Vegetables**

How many servings of fruits did you eat yesterday? This includes fresh, frozen, canned, or dried, but would not include fruit juice. ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more

How many servings of 100% fruit juice did you drink yesterday? This would not include any juice with the word "diet" or "dietary" on the label. ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more

How many servings of vegetables did you eat yesterday? This includes fresh, frozen, canned, or dried, but would not include vegetable juice or soups that were made with vegetables. Also include potatoes, salad, and other vegetables. ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more

It is recommended that adults eat or have 4-8 servings of fruits and vegetables a day. There comes an improvement! To meet this goal, I will eat: ☐ 4 or more servings of fruits and vegetables a day ☐ 5 or more servings of fruits and vegetables a day ☐ 6 or more servings of fruits and vegetables a day

Client completes

## Health Assessment (continued)

**Physical Activity**

In a usual week, how many days do you exercise for at least 30 minutes at a time? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

On days when you are active, how much time do you exercise each day? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

Do you experience any shortness of breath or dizziness of breath when you walk or climb? ☐ Yes ☐ No ☐ Don't know

Has your healthcare provider ever told you to get to increase your physical activity? ☐ Yes ☐ No ☐ Don't know

Are you limited in any way of your usual activities because of arthritis or joint symptoms? ☐ Yes ☐ No ☐ Don't know

Have you ever been told by a doctor or healthcare provider that you have arthritis, leg pain, or back pain? ☐ Yes ☐ No ☐ Don't know

It is recommended that adults are active at least 30 minutes a day on all or most days of the week. I have room to improve. To meet this goal, I will: ☐ 30 minutes total of walking or activity per day on 5-7 days a week ☐ 30 minutes total of walking or activity per day on 5-7 days a week ☐ 30 minutes total of walking or activity per day on 5-7 days a week

**Other Important Questions Related to Your Health**

During the past month have you often been bothered by feeling nervous, depressed, or hopeless? ☐ Yes ☐ No

During the past month have you often been bothered by little interest or pleasure in doing things? ☐ Yes ☐ No

During the past month have a doctor or healthcare provider ever told you that you have depression? ☐ Yes ☐ No

Are you currently taking medication for depression? ☐ Yes ☐ No

When was the last time you had more than four alcoholic drinks in one day? ☐ Never ☐ Once per month ☐ Once per 2 months ☐ Once per 3 months

Do you feel safe in your current relationship? ☐ Yes ☐ No

Have you been hit, kicked, punched, or otherwise hurt by someone in the past year? ☐ Yes ☐ No

Is there a partner from a previous relationship who is making you feel unsafe now? ☐ Yes ☐ No

How often do you use seat belts when you drive or ride in a car? ☐ Always ☐ Usually Always ☐ Sometimes ☐ Often ☐ Never

During the past 12 months, have you had a flu shot? ☐ Yes ☐ No ☐ Don't know

Have you had a pneumonia shot? ☐ Yes ☐ No ☐ Don't know

How long has it been since you've visited a dentist or a dental clinic for any reason? ☐ 0 to 6 months ☐ 7 to 12 months ☐ 13 to 24 months ☐ 25 to 36 months ☐ 37 to 48 months ☐ 49 to 60 months ☐ 61 to 72 months ☐ 73 to 84 months ☐ 85 to 96 months ☐ 97 to 108 months ☐ 109 to 120 months ☐ 121 to 132 months ☐ 133 to 144 months ☐ 145 to 156 months ☐ 157 to 168 months ☐ 169 to 180 months ☐ 181 to 192 months ☐ 193 to 204 months ☐ 205 to 216 months ☐ 217 to 228 months ☐ 229 to 240 months ☐ 241 to 252 months ☐ 253 to 264 months ☐ 265 to 276 months ☐ 277 to 288 months ☐ 289 to 300 months ☐ 301 to 312 months ☐ 313 to 324 months ☐ 325 to 336 months ☐ 337 to 348 months ☐ 349 to 360 months ☐ 361 to 372 months ☐ 373 to 384 months ☐ 385 to 396 months ☐ 397 to 408 months ☐ 409 to 420 months ☐ 421 to 432 months ☐ 433 to 444 months ☐ 445 to 456 months ☐ 457 to 468 months ☐ 469 to 480 months ☐ 481 to 492 months ☐ 493 to 504 months ☐ 505 to 516 months ☐ 517 to 528 months ☐ 529 to 540 months ☐ 541 to 552 months ☐ 553 to 564 months ☐ 565 to 576 months ☐ 577 to 588 months ☐ 589 to 600 months ☐ 601 to 612 months ☐ 613 to 624 months ☐ 625 to 636 months ☐ 637 to 648 months ☐ 649 to 660 months ☐ 661 to 672 months ☐ 673 to 684 months ☐ 685 to 696 months ☐ 697 to 708 months ☐ 709 to 720 months ☐ 721 to 732 months ☐ 733 to 744 months ☐ 745 to 756 months ☐ 757 to 768 months ☐ 769 to 780 months ☐ 781 to 792 months ☐ 793 to 804 months ☐ 805 to 816 months ☐ 817 to 828 months ☐ 829 to 840 months ☐ 841 to 852 months ☐ 853 to 864 months ☐ 865 to 876 months ☐ 877 to 888 months ☐ 889 to 900 months ☐ 901 to 912 months ☐ 913 to 924 months ☐ 925 to 936 months ☐ 937 to 948 months ☐ 949 to 960 months ☐ 961 to 972 months ☐ 973 to 984 months ☐ 985 to 996 months ☐ 997 to 1008 months ☐ 1009 to 1020 months ☐ 1021 to 1032 months ☐ 1033 to 1044 months ☐ 1045 to 1056 months ☐ 1057 to 1068 months ☐ 1069 to 1080 months ☐ 1081 to 1092 months ☐ 1093 to 1104 months ☐ 1105 to 1116 months ☐ 1117 to 1128 months ☐ 1129 to 1140 months ☐ 1141 to 1152 months ☐ 1153 to 1164 months ☐ 1165 to 1176 months ☐ 1177 to 1188 months ☐ 1189 to 1200 months ☐ 1201 to 1212 months ☐ 1213 to 1224 months ☐ 1225 to 1236 months ☐ 1237 to 1248 months ☐ 1249 to 1260 months ☐ 1261 to 1272 months ☐ 1273 to 1284 months ☐ 1285 to 1296 months ☐ 1297 to 1308 months ☐ 1309 to 1320 months ☐ 1321 to 1332 months ☐ 1333 to 1344 months ☐ 1345 to 1356 months ☐ 1357 to 1368 months ☐ 1369 to 1380 months ☐ 1381 to 1392 months ☐ 1393 to 1404 months ☐ 1405 to 1416 months ☐ 1417 to 1428 months ☐ 1429 to 1440 months ☐ 1441 to 1452 months ☐ 1453 to 1464 months ☐ 1465 to 1476 months ☐ 1477 to 1488 months ☐ 1489 to 1500 months ☐ 1501 to 1512 months ☐ 1513 to 1524 months ☐ 1525 to 1536 months ☐ 1537 to 1548 months ☐ 1549 to 1560 months ☐ 1561 to 1572 months ☐ 1573 to 1584 months ☐ 1585 to 1596 months ☐ 1597 to 1608 months ☐ 1609 to 1620 months ☐ 1621 to 1632 months ☐ 1633 to 1644 months ☐ 1645 to 1656 months ☐ 1657 to 1668 months ☐ 1669 to 1680 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2221 to 2232 months ☐ 2233 to 2244 months ☐ 2245 to 2256 months ☐ 2257 to 2268 months ☐ 2269 to 2280 months ☐ 2281 to 2292 months ☐ 2293 to 2304 months ☐ 2305 to 2316 months ☐ 2317 to 2328 months ☐ 2329 to 2340 months ☐ 2341 to 2352 months ☐ 2353 to 2364 months ☐ 2365 to 2376 months ☐ 2377 to 2388 months ☐ 2389 to 2400 months ☐ 2401 to 2412 months ☐ 2413 to 2424 months ☐ 2425 to 2436 months ☐ 2437 to 2448 months ☐ 2449 to 2460 months ☐ 2461 to 2472 months ☐ 2473 to 2484 months ☐ 2485 to 2496 months ☐ 2497 to 2508 months ☐ 2509 to 2520 months ☐ 2521 to 2532 months ☐ 2533 to 2544 months ☐ 2545 to 2556 months ☐ 2557 to 2568 months ☐ 2569 to 2580 months ☐ 2581 to 2592 months ☐ 2593 to 2604 months ☐ 2605 to 2616 months ☐ 2617 to 2628 months ☐ 2629 to 2640 months ☐ 2641 to 2652 months ☐ 2653 to 2664 months ☐ 2665 to 2676 months ☐ 2677 to 2688 months ☐ 2689 to 2700 months ☐ 2701 to 2712 months ☐ 2713 to 2724 months ☐ 2725 to 2736 months ☐ 2737 to 2748 months ☐ 2749 to 2760 months ☐ 2761 to 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months ☐ 3313 to 3324 months ☐ 3325 to 3336 months ☐ 3337 to 3348 months ☐ 3349 to 3360 months ☐ 3361 to 3372 months ☐ 3373 to 3384 months ☐ 3385 to 3396 months ☐ 3397 to 3408 months ☐ 3409 to 3420 months ☐ 3421 to 3432 months ☐ 3433 to 3444 months ☐ 3445 to 3456 months ☐ 3457 to 3468 months ☐ 3469 to 3480 months ☐ 3481 to 3492 months ☐ 3493 to 3504 months ☐ 3505 to 3516 months ☐ 3517 to 3528 months ☐ 3529 to 3540 months ☐ 3541 to 3552 months ☐ 3553 to 3564 months ☐ 3565 to 3576 months ☐ 3577 to 3588 months ☐ 3589 to 3600 months ☐ 3601 to 3612 months ☐ 3613 to 3624 months ☐ 3625 to 3636 months ☐ 3637 to 3648 months ☐ 3649 to 3660 months ☐ 3661 to 3672 months ☐ 3673 to 3684 months ☐ 3685 to 3696 months ☐ 3697 to 3708 months ☐ 3709 to 3720 months ☐ 3721 to 3732 months ☐ 3733 to 3744 months ☐ 3745 to 3756 months ☐ 3757 to 3768 months ☐ 3769 to 3780 months ☐ 3781 to 3792 months ☐ 3793 to 3804 months ☐ 3805 to 3816 months ☐ 3817 to 3828 months ☐ 3829 to 3840 months ☐ 3841 to 3852 months ☐ 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months ☐ 4945 to 4956 months ☐ 4957 to 4968 months ☐ 4969 to 4980 months ☐ 4981 to 4992 months ☐ 4993 to 5004 months ☐ 5005 to 5016 months ☐ 5017 to 5028 months ☐ 5029 to 5040 months ☐ 5041 to 5052 months ☐ 5053 to 5064 months ☐ 5065 to 5076 months ☐ 5077 to 5088 months ☐ 5089 to 5100 months ☐ 5101 to 5112 months ☐ 5113 to 5124 months ☐ 5125 to 5136 months ☐ 5137 to 5148 months ☐ 5149 to 5160 months ☐ 5161 to 5172 months ☐ 5173 to 5184 months ☐ 5185 to 5196 months ☐ 5197 to 5208 months ☐ 5209 to 5220 months ☐ 5221 to 5232 months ☐ 5233 to 5244 months ☐ 5245 to 5256 months ☐ 5257 to 5268 months ☐ 5269 to 5280 months ☐ 5281 to 5292 months ☐ 5293 to 5304 months ☐ 5305 to 5316 months ☐ 5317 to 5328 months ☐ 5329 to 5340 months ☐ 5341 to 5352 months ☐ 5353 to 5364 months ☐ 5365 to 5376 months ☐ 5377 to 5388 months ☐ 5389 to 5400 months ☐ 5401 to 5412 months ☐ 5413 to 5424 months ☐ 5425 to 5436 months ☐ 5437 to 5448 months ☐ 5449 to 5460 months ☐ 5461 to 5472 months ☐ 5473 to 5484 months ☐ 5485 to 5496 months ☐ 5497 to 5508 months ☐ 5509 to 5520 months ☐ 5521 to 5532 months ☐ 5533 to 5544 months ☐ 5545 to 5556 months ☐ 5557 to 5568 months ☐ 5569 to 5580 months ☐ 5581 to 5592 months ☐ 5593 to 5604 months ☐ 5605 to 5616 months ☐ 5617 to 5628 months ☐ 5629 to 5640 months ☐ 5641 to 5652 months ☐ 5653 to 5664 months ☐ 5665 to 5676 months ☐ 5677 to 5688 months ☐ 5689 to 5700 months ☐ 5701 to 5712 months ☐ 5713 to 5724 months ☐ 5725 to 5736 months ☐ 5737 to 5748 months ☐ 5749 to 5760 months ☐ 5761 to 5772 months ☐ 5773 to 5784 months ☐ 5785 to 5796 months ☐ 5797 to 5808 months ☐ 5809 to 5820 months ☐ 5821 to 5832 months ☐ 5833 to 5844 months ☐ 5845 to 5856 months ☐ 5857 to 5868 months ☐ 5869 to 5880 months ☐ 5881 to 5892 months ☐ 5893 to 5904 months ☐ 5905 to 5916 months ☐ 5917 to 5928 months ☐ 5929 to 5940 months ☐ 5941 to 5952 months ☐ 5953 to 5964 months ☐ 5965 to 5976 months ☐ 5977 to 5988 months ☐ 5989 to 6000 months ☐ 6001 to 6012 months ☐ 6013 to 6024 months ☐ 6025 to 6036 months ☐ 6037 to 6048 months ☐ 6049 to 6060 months ☐ 6061 to 6072 months ☐ 6073 to 6084 months ☐ 6085 to 6096 months ☐ 6097 to 6108 months ☐ 6109 to 6120 months ☐ 6121 to 6132 months ☐ 6133 to 6144 months ☐ 6145 to 6156 months ☐ 6157 to 6168 months ☐ 6169 to 6180 months ☐ 6181 to 6192 months ☐ 6193 to 6204 months ☐ 6205 to 6216 months ☐ 6217 to 6228 months ☐ 6229 to 6240 months ☐ 6241 to 6252 months ☐ 6253 to 6264 months ☐ 6265 to 6276 months ☐ 6277 to 6288 months ☐ 6289 to 6300 months ☐ 6301 to 6312 months ☐ 6313 to 6324 months ☐ 6325 to 6336 months ☐ 6337 to 6348 months ☐ 6349 to 6360 months ☐ 6361 to 6372 months ☐ 6373 to 6384 months ☐ 6385 to 6396 months ☐ 6397 to 6408 months ☐ 6409 to 6420 months ☐ 6421 to 6432 months ☐ 6433 to 6444 months ☐ 6445 to 6456 months ☐ 6457 to 6468 months ☐ 6469 to 6480 months ☐ 6481 to 6492 months ☐ 6493 to 6504 months ☐ 6505 to 6516 months ☐ 6517 to 6528 months ☐ 6529 to 6540 months ☐ 6541 to 6552 months ☐ 6553 to 6564 months ☐ 6565 to 6576 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Screening Visit Clients 40-64 Years		
Exams Clients Should Receive:	Paperwork the healthcare provider completes:	What you give the client:
<ol style="list-style-type: none"> <li>1. Clinical Breast Exam-Annually</li> <li>2. Teach/Review Breast Self Exam</li> <li>3. Mammography <ul style="list-style-type: none"> <li>• 40-49: every 1-2 years at discretion of clinician</li> <li>• 50+: Annually</li> </ul> </li> <li>4. Pelvic Exam*</li> <li>5. Screening Pap test biennially (every 2 years)</li> <li>6. Blood pressure (two readings are required during visit)**</li> <li>7. Fasting Lipid Panel or Basic Metabolic Panel to include total cholesterol and HDL timing in accordance with screening guidelines-see page 3-24**</li> <li>8. Fasting blood glucose or A1c timing in accordance with screening guidelines-see page 3-18**</li> <li>9. Weight, Height with shoes off, and Waist Circumference**</li> <li>10. Risk factor evaluation based on the Health Risk Assessment on the Screening Visit Card**</li> </ol>	<ol style="list-style-type: none"> <li>1. Page 3 of Pink Enrollment or EWM Screening Card that the client brought with her. If cholesterol and glucose results are not immediately available, record when available. Submit Screening Visit Card to EWM within two (2) weeks of date of service.</li> <li>2. EWM Mammography Reporting Form (<b>gray shaded area must be completed by the healthcare provider</b>).</li> <li>3. Affix the Red and White sticker to the lab requisition for the Pap test evaluation so the lab will bill EWM.  For clinics using electronic submission of lab requisition indicate EWM for billing purposes.</li> </ol> <p>Example Sticker:</p> <div style="border: 1px solid black; padding: 10px; text-align: center;"> <b>Every Woman Matters</b>  <b>1-800-532-2227</b> </div> <p>(Example of Pink Enrollment and Screening Visit Card located on page 3-7)</p>	<ol style="list-style-type: none"> <li>1. EWM Mammography Reporting Form (if mammogram ordered) (<b>gray shaded area must be completed by the healthcare provider</b>) for the client to take to an approved mammography facility.</li> <li>2. Screening Visit Card (pages 4 and 5) for client to take with her. These two pages give the client and healthcare provider a place to write down the client's cardiovascular/diabetes screening results. This is also a place for the client and healthcare provider to talk about goals to improve the clients' cardiovascular/diabetes health.</li> </ol> <p>(Example of EWM Mammography Reporting Form located on page 3-7)</p>
* Pelvic exam must be in conjunction with a Pap test and/or clinical breast exam in order to be reimbursed.		
** In order to be reimbursed for these exams, cardiovascular screening must be in conjunction with breast and cervical cancer screening and follow CVD Screening Guidelines set forth on page 3-18).		



# Example forms for Screening Visit for Clients 40-64

Client completes

Client completes

Provider completes

Client and Provider completes together

Client completes

## Presumptive Eligibility Enrollment Form (pink) (6 pages)

Client completes

Client completes

Provider completes

Client and Provider completes together

## Screening Visit Card (5 pages)

Provider completes  
gray shaded area

## Mammography Reporting Form

## Diagnostic Mammography

EWM will pay for this when:	Paperwork the healthcare provider completes:	What you give the client:
<p>Clients enrolling for diagnostic services, who are 30-39 years of age and who have a palpable mass suspicious for malignancy.</p> <p><b>*EWM highly encourages every client with a suspicious breast mass to be referred to a surgeon.</b></p>	<ol style="list-style-type: none"> <li>Breast Diagnostic Enrollment/ Follow Up and Treatment Plan (Section 1 indicating referral to a surgeon)</li> <li>EWM Mammography Reporting Form (<b>gray shaded area must be completed by the healthcare provider</b>)</li> </ol>	<ol style="list-style-type: none"> <li>EWM Mammography Reporting Form (<b>gray shaded area must be completed by the healthcare provider</b>) for the client to take to an approved mammography facility.</li> </ol>
<p>Clients of at least 40 years of age, who have had a mammogram indicating Assessment Incomplete.</p>	<ol style="list-style-type: none"> <li>Breast Diagnostic Enrollment/ Follow Up and Treatment Plan (Sections 1 and 2)</li> <li>EWM Mammography Reporting Form (<b>gray shaded area must be completed by the healthcare provider</b>).</li> </ol> <p><i>(Example of the Breast Diagnostic Enrollment/Follow Up and Treatment Plan form located on page 3-9)</i></p>	<ol style="list-style-type: none"> <li>EWM Mammography Reporting Form (<b>gray shaded area must be completed by the healthcare provider</b>) for the client to take to an approved mammography facility.</li> </ol> <p><i>(Example of the EWM Mammography Reporting Form located on page 3-9)</i></p>

## Breast Ultrasound

EWM will pay for this when:	Paperwork the healthcare provider completes:	What you give the client:
<p>Client is 18-39 years old with suspicious palpable mass</p> <p><b>*Reimbursement for breast ultrasound needs preauthorization for clients 18-39, except when recommended by a radiologist following a diagnostic mammogram in clients 30-39. Preauthorization for breast ultrasound is based on funding availability.</b></p>	<ol style="list-style-type: none"> <li>Breast Diagnostic Enrollment/ Follow Up and Treatment Plan (Section 1 and Preauthorization on Page 4)</li> <li>EWM Mammography Reporting Form (<b>gray shaded area must be completed by the healthcare provider</b>)</li> </ol>	<ol style="list-style-type: none"> <li>Section 1 and 2 of the Breast Diagnostic Enrollment/Follow Up and Treatment Plan for the client to take to an approved referring surgeon.</li> <li>EWM Mammography Reporting Form (<b>gray shaded area must be completed by the healthcare provider</b>)</li> </ol>
<p>Client is 40 years old or older with suspicious breast malignancy on clinical breast exam with negative/ benign screening or diagnostic mammogram or Assessment Incomplete mammogram.</p>	<ol style="list-style-type: none"> <li>Complete Section 1 and 2 of the Breast Diagnostic Enrollment/Follow Up and Treatment Plan</li> <li>EWM Mammography Reporting Form (<b>gray shaded area must be completed by the healthcare provider</b>).</li> </ol> <p><i>(Example of the Breast Diagnostic Enrollment/Follow Up and Treatment Plan form located on page 3-9)</i></p>	<ol style="list-style-type: none"> <li>EWM Mammography Reporting Form (<b>gray shaded area must be completed by the healthcare provider</b>) for the client to take to an approved ultrasound facility.</li> </ol> <p><i>(Example of the EWM Mammography Reporting Form located on page 3-9)</i></p>

**NOTE:** Reimbursement for breast ultrasound needs **preauthorization** for clients 18-39, **except** when recommended by a radiologist following a diagnostic mammogram in clients 30-39. **Preauthorization** for breast ultrasound is based on funding availability.



## Breast Diagnostic Enrollment/Follow Up and Treatment Form (5 pages)

# **NEW FORM INSTRUCTIONS**

**Instructions on how to complete the Brain Diagnostic Examinations: Follow-Up and Treatment Plan**

## **■ Use the form for all:**

- **Completed examinations** (Diagnostic Examinations, Diagnostic Examinations, Diagnostic Examinations)
- **After the final exam results and a written report of diagnostic results** (See these instructions, pages 1 and 2)
- **When the patient is referred to the BDE Program** (If the patient was previously referred to the BDE Program, the form should be completed on the second page, 11/12/13/14/15/16/17/18/19/20/21/22/23/24/25/26/27/28/29/30/31/32/33/34/35/36/37/38/39/40/41/42/43/44/45/46/47/48/49/50/51/52/53/54/55/56/57/58/59/60/61/62/63/64/65/66/67/68/69/70/71/72/73/74/75/76/77/78/79/80/81/82/83/84/85/86/87/88/89/90/91/92/93/94/95/96/97/98/99/100/101/102/103/104/105/106/107/108/109/110/111/112/113/114/115/116/117/118/119/120/121/122/123/124/125/126/127/128/129/130/131/132/133/134/135/136/137/138/139/140/141/142/143/144/145/146/147/148/149/150/151/152/153/154/155/156/157/158/159/160/161/162/163/164/165/166/167/168/169/170/171/172/173/174/175/176/177/178/179/180/181/182/183/184/185/186/187/188/189/190/191/192/193/194/195/196/197/198/199/200/201/202/203/204/205/206/207/208/209/210/211/212/213/214/215/216/217/218/219/220/221/222/223/224/225/226/227/228/229/230/231/232/233/234/235/236/237/238/239/240/241/242/243/244/245/246/247/248/249/250/251/252/253/254/255/256/257/258/259/260/261/262/263/264/265/266/267/268/269/270/271/272/273/274/275/276/277/278/279/280/281/282/283/284/285/286/287/288/289/290/291/292/293/294/295/296/297/298/299/300/301/302/303/304/305/306/307/308/309/310/311/312/313/314/315/316/317/318/319/320/321/322/323/324/325/326/327/328/329/330/331/332/333/334/335/336/337/338/339/340/341/342/343/344/345/346/347/348/349/350/351/352/353/354/355/356/357/358/359/360/361/362/363/364/365/366/367/368/369/370/371/372/373/374/375/376/377/378/379/380/381/382/383/384/385/386/387/388/389/390/391/392/393/394/395/396/397/398/399/400/401/402/403/404/405/406/407/408/409/410/411/412/413/414/415/416/417/418/419/420/421/422/423/424/425/426/427/428/429/430/431/432/433/434/435/436/437/438/439/440/441/442/443/444/445/446/447/448/449/450/451/452/453/454/455/456/457/458/459/460/461/462/463/464/465/466/467/468/469/470/471/472/473/474/475/476/477/478/479/480/481/482/483/484/485/486/487/488/489/490/491/492/493/494/495/496/497/498/499/500/501/502/503/504/505/506/507/508/509/510/511/512/513/514/515/516/517/518/519/520/521/522/523/524/525/526/527/528/529/530/531/532/533/534/535/536/537/538/539/540/541/542/543/544/545/546/547/548/549/550/551/552/553/554/555/556/557/558/559/560/561/562/563/564/565/566/567/568/569/570/571/572/573/574/575/576/577/578/579/580/581/582/583/584/585/586/587/588/589/590/591/592/593/594/595/596/597/598/599/600/601/602/603/604/605/606/607/608/609/610/611/612/613/614/615/616/617/618/619/620/621/622/623/624/625/626/627/628/629/630/631/632/633/634/635/636/637/638/639/640/641/642/643/644/645/646/647/648/649/650/651/652/653/654/655/656/657/658/659/660/661/662/663/664/665/666/667/668/669/670/671/672/673/674/675/676/677/678/679/680/681/682/683/684/685/686/687/688/689/690/691/692/693/694/695/696/697/698/699/700/701/702/703/704/705/706/707/708/709/710/711/712/713/714/715/716/717/718/719/720/721/722/723/724/725/726/727/728/729/730/731/732/733/734/735/736/737/738/739/740/741/742/743/744/745/746/747/748/749/750/751/752/753/754/755/756/757/758/759/760/761/762/763/764/765/766/767/768/769/770/771/772/773/774/775/776/777/778/779/780/781/782/783/784/785/786/787/788/789/790/791/792/793/794/795/796/797/798/799/800/801/802/803/804/805/806/807/808/809/810/811/812/813/814/815/816/817/818/819/820/821/822/823/824/825/826/827/828/829/830/831/832/833/834/835/836/837/838/839/840/841/842/843/844/845/846/847/848/849/850/851/852/853/854/855/856/857/858/859/860/861/862/863/864/865/866/867/868/869/870/871/872/873/874/875/876/877/878/879/880/881/882/883/884/885/886/887/888/889/890/891/892/893/894/895/896/897/898/899/900/901/902/903/904/905/906/907/908/909/910/911/912/913/914/915/916/917/918/919/920/921/922/923/924/925/926/927/928/929/930/931/932/933/934/935/936/937/938/939/940/941/942/943/944/945/946/947/948/949/950/951/952/953/954/955/956/957/958/959/960/961/962/963/964/965/966/967/968/969/970/971/972/973/974/975/976/977/978/979/98

Client completes

[illegible]

Client completes

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Provider completes

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Provider completes

# Every Woman Matters Mammography Reporting Form

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**Printed Patient Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Referring Physician:** \_\_\_\_\_ **Date of Exam:** \_\_\_\_\_

**Examiner:** \_\_\_\_\_  
 I am a \_\_\_\_\_ and have an additional specialty of \_\_\_\_\_.

**Referring Physician:** \_\_\_\_\_  
 \_\_\_\_\_, MD  
 \_\_\_\_\_, MD

**Referring Institution:** \_\_\_\_\_

**Referring Physician:** \_\_\_\_\_

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**Referring Physician:** \_\_\_\_\_

**Referring Physician:** \_\_\_\_\_

**Name:** \_\_\_\_\_

**Date of Service:** \_\_\_\_\_

**Mammography Findings**

**Breasts (BIRADS)**

☐ **Asymmetry** \_\_\_\_\_

☐ **Architectural Distortion** \_\_\_\_\_

☐ **Calcifications** \_\_\_\_\_

☐ **Masses** \_\_\_\_\_

☐ **Microcalcifications** \_\_\_\_\_

☐ **Other** \_\_\_\_\_

☐ **Other** \_\_\_\_\_

☐ **Other** \_\_\_\_\_

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Provider completes  
gray shaded area

# Mammography Reporting Form

## Fine Needle or Cyst Aspiration

EWM will pay for this when:	Paperwork the healthcare provider completes:	What you give the client:
Client is 18-39 years old with suspicious palpable mass	1. Breast Diagnostic Enrollment/ Follow Up and Treatment Plan (Section 1 indicating referral to surgeon)	1. If referring to another healthcare provider, give client the Breast Diagnostic Enrollment/ Follow Up and Treatment Plan to take to an approved referral healthcare provider.
Client is 40 years old or older with suspicious breast malignancy on clinical breast exam with negative/ benign screening or diagnostic mammogram or assessment incomplete mammogram.	1. Breast Diagnostic Enrollment/ Follow Up and Treatment Plan (Section 1 and 2)  <i>(Example of the Breast Diagnostic Enrollment/ Follow Up and Treatment Plan form located on page 3-11)</i>	1. If referring to another healthcare provider, give client Breast Diagnostic Enrollment/ Follow Up and Treatment Plan to take to an approved referral healthcare provider.  <i>(Example of Breast Diagnostic Enrollment/ Follow Up and Treatment Plan form located on page 3-11)</i>

## Breast Biopsy

EWM will pay for this when:	Paperwork the healthcare provider completes:	What you give the client:
Client is 18-39 years old with suspicious palpable mass	1. Breast Diagnostic Enrollment/ Follow Up and Treatment Plan (Section 1 indicating referral to surgeon)	1. If referring to another healthcare provider, give client the Breast Diagnostic Enrollment/ Follow Up and Treatment Plan to take to an approved referral healthcare provider.
Client is 40 years old or older with mammogram results of suspicious abnormality or suggestive of malignancy.	1. Breast Diagnostic Enrollment/ Follow Up and Treatment Plan (Section 1 and 2)  <i>(Example of the Breast Diagnostic Enrollment/ Follow Up and Treatment Plan form located on page 3-11)</i>	1. If referring to another healthcare provider, give client the Breast Diagnostic Enrollment/ Follow Up and Treatment Plan to take to an approved referral healthcare provider.  <i>(Example of Breast Diagnostic Enrollment/ Follow Up and Treatment Plan form located on page 3-11)</i>

## Page 3-11

[illegible]

Client completes

Client completes

Provider completes[illegible]

## Preauthorization - Pap Test for Short Interval Follow Up

EWM will pay for this when:	Paperwork the healthcare provider completes:	What you give the client:
<p>Preauthorization</p> <p>Before you contact EWM for pre-authorization, please check your request to confirm that it follows the 2006 ASCCP Guidelines.</p> <p><b>Note:</b> If the 2006 ASCCP Guidelines indicate cytology at 6 months and 12 months <b>OR</b> HPV testing at 12 months, EWM will <b>ONLY</b> pay for HPV testing at 12 months. (See Policy 10 C-7). See algorithms in Cervical Protocols Section of this manual.</p>	<p>1. Cervical Diagnostic Enrollment/Follow Up and Treatment Plan (<b>Pre-authorization portion located in Section 4</b>)</p> <p>All Surveillance/Follow Up cytology and HPV testing at 12 months to be documented under Surveillance/Follow Up Section on the Annual Screening Visit Card.</p> <p>2. Affix the Red and White Sticker to the lab requisition so the lab will bill EWM.</p> <p>For clinics using electronic submission of lab requisition indicate EWM for billing purposes.</p> <p>Example Sticker:</p> <div style="border: 1px solid black; padding: 10px; text-align: center;"> <b>Every Woman Matters</b>  <b>1-800-532-2227</b> </div> <p>(Examples of the Cervical Diagnostic Enrollment/Follow Up and Treatment Plan form are located on page 3-13)</p>	<p>1. No paperwork given to the client at this time.</p>

### SECTION 1 Screening

### SECTION 2 Diagnostic Workup

Referral Information	Clinic Information	Pap Test Finding	Recommendations	Allowable for Reimbursement
<input type="checkbox"/> Client Referred to another provider who will take over care. Referral/Clinician Information - (clinician name, clinic name, city name) (do not abbreviate clinic name) <b>SECTION 1: Screening - to be completed by the provider who initiated/completed Section 1</b> Name and Address of Clinic initiating/completing SECTION 1 _____ Date _____ (do not abbreviate clinic name)	<b>SECTION 1: Screening</b> Name and Address of Clinic initiating/completing SECTION 1 _____ Date _____ (do not abbreviate clinic name)	<input type="checkbox"/> Negative/Benign	Colposcopy with biopsy with visible suspicious cervical lesion	Colposcopy with <input type="checkbox"/> Endocervical Sampling <input type="checkbox"/> Cervical biopsy Date ____/____/____
		<input type="checkbox"/> ASC-US with +HPV <u>≥ 21 yrs</u>	Colposcopy with biopsy	
		<input type="checkbox"/> LSIL <u>≥ 21 yrs</u>		
		<input type="checkbox"/> ASC-H <u>≥ 18 yrs</u>		
		<input type="checkbox"/> HSIL 18-20 yrs	Immediate LEEP unacceptable	Colposcopy with <input type="checkbox"/> Endocervical Sampling <input type="checkbox"/> Cervical biopsy Date ____/____/____
		<input type="checkbox"/> HSIL <u>≥ 21 yrs</u>	Colposcopy with biopsy or LEEP with strong consideration for colposcopy first instead of treatment for younger women	
		<input type="checkbox"/> Squamous Cell Carcinoma	Treatment referral to OB/GYN	Complete Section 3
		<input type="checkbox"/> AGC Results 18-34 yrs Endometrial biopsy criteria: <input type="checkbox"/> Abnormal vaginal bleeding <input type="checkbox"/> Obesity BMI <input type="checkbox"/> Polycystic Ovarian Syndrome (PCOS) <input type="checkbox"/> Other conditions leading to chronic anovulation	Atypical Endometrial Cells	AGC Results All three procedures must be performed on same day Colposcopy with <input type="checkbox"/> Endocervical Sampling <input type="checkbox"/> Cervical biopsy <input type="checkbox"/> HPV Testing Date ____/____/____ <input type="checkbox"/> Endometrial biopsy <input type="checkbox"/> Endocervical sampling Both procedures must be performed on same day EWM may request documentation to support diagnosis
		<input type="checkbox"/> AGC <u>≥ 35 yrs</u>		All other AGC Paps- AG-NOS, AGC-probable endocervical cells Colposcopy with <input type="checkbox"/> Endocervical Sampling <input type="checkbox"/> Cervical biopsy <input type="checkbox"/> HPV Testing Date ____/____/____ <input type="checkbox"/> Endometrial biopsy All three procedures must be performed on same day
		<input type="checkbox"/> HPV (+) Surveillance testing <u>≥ 21 yrs</u>	Colposcopy with biopsy	Colposcopy with <input type="checkbox"/> Endocervical Sampling <input type="checkbox"/> Cervical biopsy Date ____/____/____



## Cervical Diagnostic Enrollment/Follow Up and Treatment Form (6 pages)

Instructions for Providers	Provider Education	Client completes
----------------------------	--------------------	------------------

Client completes

Provider completes

Provider completes

## Colposcopy and Colposcopy-directed biopsy

EWM will pay for this when:	Paperwork the healthcare provider completes:	What you give the client:
Services are allowable based upon the Cervical Diagnostic Enrollment/Follow Up and Treatment Plan criteria listed below:	<p>1. If referring or performing, complete Cervical Diagnostic Enrollment/Follow Up and Treatment Plan (Section 1 or 2).</p> <p>2. Affix the Red and White Sticker to the lab requisition so the lab will bill EWM.</p> <p>For clinics using electronic submission of lab requisition indicate EWM for billing purposes.</p> <p>Example Sticker:</p> <div style="border: 1px solid black; padding: 10px; text-align: center;"> <b>Every Woman Matters</b>  <b>1-800-532-2227</b> </div> <p>(Example of the Cervical Diagnostic Enrollment/Follow Up and Treatment Plan form located on page 3-15)</p>	<p>1. If referring to another healthcare provider, give client the Cervical Diagnostic Enrollment/Follow Up and Treatment Plan to take to an approved referral healthcare provider.</p> <p>(Example of the Cervical Diagnostic Enrollment/Follow Up and Treatment Plan form located on page 3-15)</p>
<b>NOTE:</b> Expect that 98% of clients receive colposcopy with biopsy.		

### SECTION 1 Screening

### SECTION 2 Diagnostic Workup

Referral Information	Clinic Information	Pap Test Finding	Recommendations	Allowable for Reimbursement	
<input type="checkbox"/> Client Referred to another provider who will take over care.  <small>Referral Clinician Information - clinician name, clinic name, city name (do not abbreviate clinic name)</small> <b>SECTION 1: Screening - to be completed by the provider who initiated/completed Section 1</b>	<small>Name and Address of Clinic initiating/completing SECTION 1</small> <small>Date</small> <small>(do not abbreviate clinic name)</small>	<input type="checkbox"/> Negative/Benign	Colposcopy with biopsy with visible suspicious cervical lesion	Colposcopy with <input type="checkbox"/> Endocervical Sampling <input type="checkbox"/> Cervical biopsy      Date ____/____/____	
		<input type="checkbox"/> ASC-US with +HPV ≥ 21 yrs <input type="checkbox"/> LSIL ≥ 21 yrs <input type="checkbox"/> ASC-H ≥ 18 yrs	Colposcopy with biopsy		
		<input type="checkbox"/> HSIL 18-20 yrs	Immediate LEEP unacceptable		
		<input type="checkbox"/> HSIL ≥ 21 yrs	Colposcopy with biopsy or LEEP with strong consideration for colposcopy first instead of treatment for younger women		
		<input type="checkbox"/> Squamous Cell Carcinoma	Treatment referral to OB/GYN	Complete Section 3	
		<input type="checkbox"/> AGC Results 18-34 yrs Endometrial biopsy criteria: <input type="checkbox"/> Abnormal vaginal bleeding <input type="checkbox"/> Obesity BMI <input type="checkbox"/> Polycystic Ovarian Syndrome (PCOS) <input type="checkbox"/> Other conditions leading to chronic anovulation	<input type="checkbox"/> AGC ≥ 35 yrs	Atypical Endometrial Cells  All other AGC Paps-AG-NOS, AGC-probable endocervical cells	AGC Results      All three procedures must be performed on same day Colposcopy with <input type="checkbox"/> Endocervical Sampling <input type="checkbox"/> Cervical biopsy <input type="checkbox"/> HPV Testing <input type="checkbox"/> Endometrial biopsy      Date ____/____/____ EWM may request documentation to support diagnosis
		<input type="checkbox"/> HPV (+) Surveillance testing ≥ 21 yrs	Colposcopy with biopsy	Colposcopy with <input type="checkbox"/> Endocervical Sampling <input type="checkbox"/> Cervical biopsy <input type="checkbox"/> HPV Testing <input type="checkbox"/> Endometrial biopsy      Date ____/____/____	
					All three procedures must be performed on same day Colposcopy with <input type="checkbox"/> Endocervical Sampling <input type="checkbox"/> Cervical biopsy <input type="checkbox"/> HPV Testing <input type="checkbox"/> Endometrial biopsy      Date ____/____/____



# Example forms for Colposcopy and Colposcopy-directed Biopsy

## Cervical Diagnostic Enrollment/Follow Up and Treatment Form (6 pages)

**NEW FORM INSTRUCTIONS**

**Instructions on how to complete the Cervical Diagnostic Enrollment / Follow Up and Treatment Plan:**

- To be filled out by the provider.
- Section 1: General Information. This section contains information about the patient and the provider. It includes a space for the provider's name, address, and phone number, and a space for the patient's name, date of birth, and address.
- Section 2: Cervical Diagnostic Enrollment / Follow Up and Treatment Plan. This section contains information about the patient's cervical diagnostic enrollment, follow up, and treatment plan. It includes a space for the provider to indicate the patient's enrollment status, follow up status, and treatment plan.
- Section 3: Patient Information. This section contains information about the patient's medical history, including a space for the provider to indicate the patient's history of cervical cancer, HPV infection, and other relevant medical conditions.
- Section 4: Provider Information. This section contains information about the provider's qualifications, including a space for the provider to indicate their medical degree, board certification, and other relevant information.
- Section 5: Consent. This section contains a space for the patient to sign a consent form, indicating that they understand the risks and benefits of the procedure and agree to the treatment plan.
- Section 6: Signature. This section contains a space for the provider to sign the form, indicating that they have completed the enrollment, follow up, and treatment plan.

**Important Information for Cervical Diagnostic Follow-Up**

- This form is a Cervical Diagnostic Enrollment / Follow Up and Treatment Plan. It is not a Cervical Diagnostic Enrollment / Follow Up and Treatment Plan. It is a Cervical Diagnostic Enrollment / Follow Up and Treatment Plan.
- This form is a Cervical Diagnostic Enrollment / Follow Up and Treatment Plan. It is not a Cervical Diagnostic Enrollment / Follow Up and Treatment Plan. It is a Cervical Diagnostic Enrollment / Follow Up and Treatment Plan.
- This form is a Cervical Diagnostic Enrollment / Follow Up and Treatment Plan. It is not a Cervical Diagnostic Enrollment / Follow Up and Treatment Plan. It is a Cervical Diagnostic Enrollment / Follow Up and Treatment Plan.

Instructions for Providers

Provider Education

Client completes

**Inform Consent and Release of Medical Information**

This form is to be completed by the patient, indicating that they understand the risks and benefits of the procedure and agree to the treatment plan.

**Consent:**

I, the undersigned, do hereby consent to the performance of the procedure described above, and I understand that I am responsible for the results of the procedure. I understand that I am responsible for the results of the procedure.

**Release of Medical Information:**

I, the undersigned, do hereby release the provider from any and all liability for the results of the procedure. I understand that I am responsible for the results of the procedure.

Client completes

**Cervical Diagnostic Enrollment / Follow Up and Treatment Plan**

**Section 1: General Information**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Section 2: Cervical Diagnostic Enrollment / Follow Up and Treatment Plan**

Enrollment Status: ☐ New ☐ Renewal

Follow Up Status: ☐ Yes ☐ No

Treatment Plan: ☐ Colposcopy with Biopsy ☐ Colposcopy with Biopsy and Cervical Sampling

**Section 3: Patient Information**

History of Cervical Cancer: ☐ Yes ☐ No

History of HPV Infection: ☐ Yes ☐ No

Other Medical Conditions: \_\_\_\_\_

**Section 4: Provider Information**

Provider Name: \_\_\_\_\_

Provider Address: \_\_\_\_\_

Provider Phone Number: \_\_\_\_\_

**Section 5: Consent**

I, the undersigned, do hereby consent to the performance of the procedure described above, and I understand that I am responsible for the results of the procedure. I understand that I am responsible for the results of the procedure.

**Section 6: Signature**

Provider Signature: \_\_\_\_\_

Provider completes

**Section 1: General Information**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Section 2: Cervical Diagnostic Enrollment / Follow Up and Treatment Plan**

Enrollment Status: ☐ New ☐ Renewal

Follow Up Status: ☐ Yes ☐ No

Treatment Plan: ☐ Colposcopy with Biopsy ☐ Colposcopy with Biopsy and Cervical Sampling

**Section 3: Patient Information**

History of Cervical Cancer: ☐ Yes ☐ No

History of HPV Infection: ☐ Yes ☐ No

Other Medical Conditions: \_\_\_\_\_

**Section 4: Provider Information**

Provider Name: \_\_\_\_\_

Provider Address: \_\_\_\_\_

Provider Phone Number: \_\_\_\_\_

**Section 5: Consent**

I, the undersigned, do hereby consent to the performance of the procedure described above, and I understand that I am responsible for the results of the procedure. I understand that I am responsible for the results of the procedure.

**Section 6: Signature**

Provider Signature: \_\_\_\_\_

Provider completes

## LEEP for Diagnosis

EWM will pay for this when:	Paperwork the healthcare provider completes:	What you give the client:
Procedure is performed, based upon the Cervical Diagnostic Enrollment/Follow Up and Treatment Plan criteria listed below:	<p>1. If referring or performing, complete Cervical Diagnostic Enrollment/Follow Up and Treatment Plan (Section 1 or 2).</p> <p>2. Affix the Red and White Sticker to the lab requisition so the lab will bill EWM.</p> <p>For clinics using electronic submission of lab requisition indicate EWM for billing purposes.</p> <p>Example Sticker:</p> <div style="border: 1px solid black; padding: 10px; text-align: center;"> <b>Every Woman Matters</b>  <b>1-800-532-2227</b> </div> <p>(Example of the Cervical Diagnostic Enrollment/Follow Up and Treatment Plan form located on page 3-17)</p>	<p>1. If referring to another healthcare provider, give client the Cervical Diagnostic Enrollment/Follow Up and Treatment Plan to take to an approved referral healthcare provider.</p> <p>(Example of the Cervical Diagnostic Enrollment/Follow Up and Treatment Plan form located on page 3-17)</p>

## SECTION 1 Screening

## SECTION 2 Diagnostic Workup

Referral Information	Clinic Information	Pap Test Finding	Recommendations	Allowable for Reimbursement	
<input type="checkbox"/> Client Referred to another provider who will take over care.	Referral/Clinician Information - clinician name, clinic name, city name (do not abbreviate clinic name)  <b>SECTION 1: Screening - to be completed by the provider who initiated/completed Section 1</b>  Name and Address of Clinic initiating/completing SECTION 1 Date _____ (do not abbreviate clinic name)	<input type="checkbox"/> Negative/Benign	Colposcopy with biopsy with visible suspicious cervical lesion	Colposcopy with <input type="checkbox"/> Endocervical Sampling <input type="checkbox"/> Cervical biopsy      Date ____/____/____	
		<input type="checkbox"/> ASC-US with +HPV ≥ 21 yrs	Colposcopy with biopsy		
		<input type="checkbox"/> LSIL ≥ 21 yrs			
		<input type="checkbox"/> ASC-H ≥ 18 yrs			
		<input type="checkbox"/> HSIL 18-20 yrs	Immediate LEEP unacceptable	Colposcopy with <input type="checkbox"/> Endocervical Sampling <input type="checkbox"/> Cervical biopsy      Date ____/____/____  <b>OR</b> <input type="checkbox"/> LEEP      Date ____/____/____	
		<input type="checkbox"/> HSIL ≥ 21 yrs	Colposcopy with biopsy or LEEP with strong consideration for colposcopy first instead of treatment for younger women		
		<input type="checkbox"/> Squamous Cell Carcinoma	Treatment referral to OB/GYN		Complete Section 3
		<input type="checkbox"/> AGC Results 18-34 yrs Endometrial biopsy criteria: <input type="checkbox"/> Abnormal vaginal bleeding <input type="checkbox"/> Obesity BMI <input type="checkbox"/> Polycystic Ovarian Syndrome (PCOS) <input type="checkbox"/> Other conditions leading to chronic anovulation	Atypical Endometrial Cells		AGC Results      All three procedures must be performed on same day Colposcopy with <input type="checkbox"/> Endocervical Sampling <input type="checkbox"/> Cervical biopsy      Date ____/____/____ <input type="checkbox"/> HPV Testing <input type="checkbox"/> Endometrial biopsy      Date ____/____/____ <i>EWM may request documentation to support diagnosis</i>
<input type="checkbox"/> AGC ≥ 35 yrs	All other AGC Paps-AG-NOS, AGC-probable endocervical cells	<input type="checkbox"/> Endometrial biopsy      Both procedures must be performed on same day <input type="checkbox"/> Endocervical sampling      Date ____/____/____			
<input type="checkbox"/> HPV (+) Surveillance testing ≥ 21 yrs	Colposcopy with biopsy	Colposcopy with <input type="checkbox"/> Endocervical Sampling <input type="checkbox"/> Cervical biopsy      Date ____/____/____ <input type="checkbox"/> HPV Testing <input type="checkbox"/> Endometrial biopsy      Date ____/____/____			

## Page 3-17

# Screening Guidelines

Client completes

Client completes

Provider completesProvider completes

## Cardiovascular / Diabetes Screening

EWM CVD/Diabetes Screening services:	EWM will pay for this when:	Paperwork the healthcare provider completes:	Follow Up services:
<ol style="list-style-type: none"> <li>1. Height/Weight Measurements</li> <li>2. Two blood pressure readings</li> <li>3. Waist circumference measurement</li> <li>4. Total cholesterol test and HDL</li> <li>5. Fasting blood glucose or an HgA1C test if client diagnosed diabetic</li> </ol>	<ol style="list-style-type: none"> <li>1. Client 40-64 is brand new to the EWM Program (never been enrolled or screened at anytime). Client is eligible to receive an initial CVD screening at her first breast and cervical visit.</li> <li>2. Client 40-64 is eligible to receive a second required CVD screen at her next annual B&amp;C visit (12-18 months after initial screening).</li> <li>3. Client 40-64 and is at risk based on health history and/or previous lab results or according to National Guidelines and EWM Program Policies.</li> </ol> <p><b>NOTE: Client Screening history on label on front of Screening Visit Card.</b></p>	<ol style="list-style-type: none"> <li>1. Page 3 of the Screening Visit Card within the red box and the recommended goals to improve the clients' CVD/Diabetes health.  <b>The Screening Visit Card must be submitted to EWM in order to receive payment for the screening visit.</b></li> <li>2. Counsel the client on the healthcare provider's interpretation of the test results and the recommended treatment, including a review of all results, medications ordered, lifestyle modifications, interventions recommended, and accessible community resources.</li> </ol>	<ol style="list-style-type: none"> <li>1. Give client the "Heart Health Results and Information" (pages 4 and 5) from the Screening Visit Card to take with her. These two pages give the client and healthcare provider a place to write down the client's CVD/Diabetes screening results. This is also a place for the client and healthcare provider to talk about goals to improve the clients' CVD/Diabetes health.</li> </ol> <p><i>(Example of Screening Visit Card located on page 3-19)</i></p>

### EWM does NOT pay for:

- Further diagnostic testing, such as a 12-lead EKG, stress test or other lab work not described in this manual.
- If services are needed that are NOT included on the list or if more than one strategy is recommended to address the client's medical issues, the healthcare provider should discuss possible cost/payment issues and options with the client.

### Other services client may be eligible for:

Lifestyle Interventions (LSI's) which refers to giving information to the client about lifestyle changes. Client may receive LSI's according to her lab values as noted below. (See Cardiovascular/Diabetes Protocols Section for more detailed information)

Normal: Refer to no-cost/low-cost community resources

At-risk/Abnormal: 4 month intervention management process with Regional LSI.

Blood pressure of 120-180 systolic or 80-110 diastolic

Fasting total cholesterol of 200-400 mg/dl

Fasting blood glucose 100-375 mg/dl

Alert: 4 month intervention management process with Regional Case Manager

Blood pressure of  $\geq 180$  systolic or  $\geq 110$  diastolic

Fasting total cholesterol of  $\geq 400$  mg/dl

Fasting blood glucose  $\geq 375$  mg/dl



# Example forms for Cardiovascular / Diabetes Screening

### Screening Visit Card

**NOTE:** Take this card to your appointment. Use within 3 months after receiving. This Screening Visit Card may have an expiration date on the label.

Every Woman Matters  
For Healthy Choices  
Lancet, 2010; 375: 1411-1417  
www.ewm.org.uk  
© 2010 Every Woman Matters  
Lancet, 2010; 375: 1411-1417

#### Steps to Take Now that You Received Your Screening Visit Card

- Call to make an appointment. Tell the clinic you have an Every Woman Matters (EWM) Screening Visit Card when you set a time for your visit.
- Be sure to read the Client Information Booklet that arrived with your Screening Visit Card. It is very important that you read the booklet before you go to your visit.

#### Health Assessment

Please answer the questions below before you see your healthcare provider. Your responses help us and our partner plan for future programs, education, and information related to good health.

**Have you ever been told by a doctor, nurse, or other health professional that your blood cholesterol is high?**  
☐ No ☐ Yes ☐ Don't know ☐ Want to be tested

**Have you ever been told by a doctor, nurse, or other health professional that you have high blood pressure?**  
☐ No ☐ Yes ☐ Don't know ☐ Want to be tested

**Have you ever been told by a doctor, nurse, or other health professional that you have diabetes?**  
☐ No ☐ Yes ☐ Don't know ☐ Want to be tested

**Has a doctor, nurse, or other health professional ever told you that you had any of the following heart attack related conditions: infarction, angina, coronary heart disease, or stroke?**  
☐ No ☐ Yes ☐ Don't know ☐ Want to be tested

**Has your father, brother, or son had a stroke or heart attack before age 60?**  
☐ No ☐ Yes ☐ Don't know ☐ Want to be tested

**Has your mother, sister, or daughter had a stroke or heart attack before age 60?**  
☐ No ☐ Yes ☐ Don't know ☐ Want to be tested

**Has either of your parents, your brother or sister, or your child ever been told by a doctor, nurse, or other health professional that he or she has diabetes?**  
☐ No ☐ Yes ☐ Don't know ☐ Want to be tested

**Are you currently taking medication for high cholesterol?**  
☐ No ☐ Yes ☐ Don't know ☐ Want to be tested

**Are you currently taking medication for high blood pressure?**  
☐ No ☐ Yes ☐ Don't know ☐ Want to be tested

**Are you currently taking medication for diabetes?**  
☐ No ☐ Yes ☐ Don't know ☐ Want to be tested

**Do you now smoke cigarettes?**  
☐ Never ☐ Yes ☐ No ☐ Don't know ☐ Want to be tested

**How many servings of fruits did you eat yesterday? This includes fresh, frozen, canned, or dried, but would not include fruit juice.**  
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

**How many servings of 100% fruit juice did you drink yesterday? This would not include any juice with the word drink or cocktail on the label. If it's 100% fruit juice, it's 100% fruit juice.**  
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

**How many servings of vegetables did you eat yesterday? This includes fresh, frozen, canned, dried, or as well as any vegetable juice or soups & more made with vegetables. Also includes potatoes, salad & salsa.**  
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

**It is recommended that adults eat at least 4-8 servings of fruits and vegetables a day. I have come to improve. To meet meeting this goal, I will aim for:**  
☐ 12-14 servings of fruits and vegetables a day ☐ 14-16 servings of fruits and vegetables a day

Client completes

### Health Assessment (continued)

**Physical Activity**  
 In a usual week, how many days are you active for at least 30 minutes a day? Active means brisk walking, bicycling, gardening, or anything else that causes some increase in breathing or heart rate.  
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

**On days when you are active, how much total time are you active each day?**  
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

**Do you experience any chest discomfort or discomfort of breath when you walk briskly?**  
☐ No ☐ Yes ☐ Don't know

**Has your healthcare provider ever told you not to increase your physical activity?**  
☐ No ☐ Yes ☐ Don't know

**Are you limited in any way of your usual activities because of arthritis or joint symptoms?**  
☐ No ☐ Yes ☐ Don't know

**How many times have you been told by a doctor or healthcare provider that you have arthritis, lupus, or rheumatoid?**  
☐ No ☐ Yes ☐ Don't know

**It is recommended that adults are active at least 30 minutes a day on all or most days of the week. I have come to improve. To meet meeting this goal, I will aim for:**  
☐ 150 minutes total of walking or activity per day on 3-5 days a week ☐ 300 minutes total of walking or activity per day on 5-7 days a week

**Other Important Questions Related to Your Health**  
**During the past month have you often been bothered by feeling down, depressed or hopeless?**  
☐ No ☐ Yes

**During the past month have you been bothered by little interest or pleasure in doing things?**  
☐ No ☐ Yes

**Are you currently taking medicine for depression?**  
☐ No ☐ Yes

**When was the last time you had more than four alcoholic drinks in one day?**  
☐ Other ☐ 2 or 3 months ☐ 4 or 5 months ago

**Do you feel safe in your current relationship?**  
☐ No ☐ Yes

**Have you been hit, kicked, punched or otherwise hurt by someone in the past year?**  
☐ No ☐ Yes

**Is there a partner from a previous relationship who by someone you feel unsafe now?**  
☐ No ☐ Yes

**How often do you see your teeth when you drive or ride in a car?**  
☐ Always ☐ Often ☐ Sometimes ☐ Often ☐ Never

**During the past 12 months, have you had a heart attack?**  
☐ No ☐ Yes

**Have you had a pneumonia test?**  
☐ No ☐ Yes

**How long has it been since you last visited a dentist or a dental clinic for any reason?**  
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

**When was the last time you had your eyes examined by a doctor or eye care provider?**  
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

**Please list all prescribed medications you take on a regular basis:**  
☐ No ☐ Yes

**Did you take your full dose today?**  
☐ No ☐ Yes

**Please list all over the counter medicines, vitamins or herbal supplements you take on a regular basis:**  
☐ No ☐ Yes

Client completes

### EWM Program Screening Services

**CVD/Diabetes Screening Services for Women 40 to 64 Years of Age**  
 CVD/Diabetes screening is ONLY performed for use of the following services below. (See Client Label 08/2008)

**Physical Activity**  
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

**On days when you are active, how much total time are you active each day?**  
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

**Do you experience any chest discomfort or discomfort of breath when you walk briskly?**  
☐ No ☐ Yes ☐ Don't know

**Has your healthcare provider ever told you not to increase your physical activity?**  
☐ No ☐ Yes ☐ Don't know

**Are you limited in any way of your usual activities because of arthritis or joint symptoms?**  
☐ No ☐ Yes ☐ Don't know

**How many times have you been told by a doctor or healthcare provider that you have arthritis, lupus, or rheumatoid?**  
☐ No ☐ Yes ☐ Don't know

**It is recommended that adults are active at least 30 minutes a day on all or most days of the week. I have come to improve. To meet meeting this goal, I will aim for:**  
☐ 150 minutes total of walking or activity per day on 3-5 days a week ☐ 300 minutes total of walking or activity per day on 5-7 days a week

**Other Important Questions Related to Your Health**  
**During the past month have you often been bothered by feeling down, depressed or hopeless?**  
☐ No ☐ Yes

**During the past month have you been bothered by little interest or pleasure in doing things?**  
☐ No ☐ Yes

**Are you currently taking medicine for depression?**  
☐ No ☐ Yes

**When was the last time you had more than four alcoholic drinks in one day?**  
☐ Other ☐ 2 or 3 months ☐ 4 or 5 months ago

**Do you feel safe in your current relationship?**  
☐ No ☐ Yes

**Have you been hit, kicked, punched or otherwise hurt by someone in the past year?**  
☐ No ☐ Yes

**Is there a partner from a previous relationship who by someone you feel unsafe now?**  
☐ No ☐ Yes

**How often do you see your teeth when you drive or ride in a car?**  
☐ Always ☐ Often ☐ Sometimes ☐ Often ☐ Never

**During the past 12 months, have you had a heart attack?**  
☐ No ☐ Yes

**Have you had a pneumonia test?**  
☐ No ☐ Yes

**How long has it been since you last visited a dentist or a dental clinic for any reason?**  
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

**When was the last time you had your eyes examined by a doctor or eye care provider?**  
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

**Please list all prescribed medications you take on a regular basis:**  
☐ No ☐ Yes

**Did you take your full dose today?**  
☐ No ☐ Yes

**Please list all over the counter medicines, vitamins or herbal supplements you take on a regular basis:**  
☐ No ☐ Yes

**Physical Activity**  
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

**On days when you are active, how much total time are you active each day?**  
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

**Do you experience any chest discomfort or discomfort of breath when you walk briskly?**  
☐ No ☐ Yes ☐ Don't know

**Has your healthcare provider ever told you not to increase your physical activity?**  
☐ No ☐ Yes ☐ Don't know

**Are you limited in any way of your usual activities because of arthritis or joint symptoms?**  
☐ No ☐ Yes ☐ Don't know

**How many times have you been told by a doctor or healthcare provider that you have arthritis, lupus, or rheumatoid?**  
☐ No ☐ Yes ☐ Don't know

**It is recommended that adults are active at least 30 minutes a day on all or most days of the week. I have come to improve. To meet meeting this goal, I will aim for:**  
☐ 150 minutes total of walking or activity per day on 3-5 days a week ☐ 300 minutes total of walking or activity per day on 5-7 days a week

**Other Important Questions Related to Your Health**  
**During the past month have you often been bothered by feeling down, depressed or hopeless?**  
☐ No ☐ Yes

**During the past month have you been bothered by little interest or pleasure in doing things?**  
☐ No ☐ Yes

**Are you currently taking medicine for depression?**  
☐ No ☐ Yes

**When was the last time you had more than four alcoholic drinks in one day?**  
☐ Other ☐ 2 or 3 months ☐ 4 or 5 months ago

**Do you feel safe in your current relationship?**  
☐ No ☐ Yes

**Have you been hit, kicked, punched or otherwise hurt by someone in the past year?**  
☐ No ☐ Yes

**Is there a partner from a previous relationship who by someone you feel unsafe now?**  
☐ No ☐ Yes

**How often do you see your teeth when you drive or ride in a car?**  
☐ Always ☐ Often ☐ Sometimes ☐ Often ☐ Never

**During the past 12 months, have you had a heart attack?**  
☐ No ☐ Yes

**Have you had a pneumonia test?**  
☐ No ☐ Yes

**How long has it been since you last visited a dentist or a dental clinic for any reason?**  
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

**When was the last time you had your eyes examined by a doctor or eye care provider?**  
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**Please list all prescribed medications you take on a regular basis:**  
☐ No ☐ Yes

**Did you take your full dose today?**  
☐ No ☐ Yes

**Please list all over the counter medicines, vitamins or herbal supplements you take on a regular basis:**  
☐ No ☐ Yes

**Physical Activity**  
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

**On days when you are active, how much total time are you active each day?**  
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

**Do you experience any chest discomfort or discomfort of breath when you walk briskly?**  
☐ No ☐ Yes ☐ Don't know

**Has your healthcare provider ever told you not to increase your physical activity?**  
☐ No ☐ Yes ☐ Don't know

**Are you limited in any way of your usual activities because of arthritis or joint symptoms?**  
☐ No ☐ Yes ☐ Don't know

**How many times have you been told by a doctor or healthcare provider that you have arthritis, lupus, or rheumatoid?**  
☐ No ☐ Yes ☐ Don't know

**It is recommended that adults are active at least 30 minutes a day on all or most days of the week. I have come to improve. To meet meeting this goal, I will aim for:**  
☐ 150 minutes total of walking or activity per day on 3-5 days a week ☐ 300 minutes total of walking or activity per day on 5-7 days a week

**Other Important Questions Related to Your Health**  
**During the past month have you often been bothered by feeling down, depressed or hopeless?**  
☐ No ☐ Yes

**During the past month have you been bothered by little interest or pleasure in doing things?**  
☐ No ☐ Yes

**Are you currently taking medicine for depression?**  
☐ No ☐ Yes

**When was the last time you had more than four alcoholic drinks in one day?**  
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**During the past 12 months, have you had a heart attack?**  
☐ No ☐ Yes

**Have you had a pneumonia test?**  
☐ No ☐ Yes

**How long has**

Other Follow Up Guidelines		
Follow Up Timeliness Parameters	Report of Women Deemed Lost to Follow Up	Client's Refusal of Services
<p>The funder of this program, the Centers for Disease Control and Prevention, has set parameters for acceptable timeliness between screening and diagnosis and between diagnosis and treatment. These parameters are:</p> <ul style="list-style-type: none"> <li>No more than 60 days should elapse between screening and diagnosis</li> <li>No more than 60 days should elapse between diagnosis and the initiation of treatment</li> </ul>	<p>All providers must make at least three (3) documented attempts at follow up for clients with abnormal results. The documentation must include the dates and types of contact as well as the results of the contact. Once a provider has exhausted all conventional means to contact a client to return for follow up, the client can be deemed lost to follow up. <b>Failure to show up for a scheduled appointment does not constitute lost to follow up.</b> The provider then notifies EWM of the client's status using the Report of Women Deemed Lost to Follow Up form. EWM then attempts to locate the client to encourage her to return for follow up care.</p> <p><i>(Example of Report of Women Deemed Lost to Follow Up form located on page 3-21)</i></p>	<p>In the event of client's refusing diagnostic services or treatment services, the healthcare provider should complete the Client Informed Refusal form. Healthcare providers need to fill in the following: client name, date of birth, social security number (if she has one) and the name of the procedure or treatment the client is refusing in the left margin of the form. The form should be given to the client in person or mailed. If mailed, information should be given verbally to the client by phone to ensure that client has enough information to make an informed decision. If client fails to return or sign the Client Informed Refusal, the reverse side of the Client Informed Refusal should be completed by the healthcare provider. This will indicate whether or not the healthcare provider believes the client had enough information to make an informed decision.</p> <p><i>(Example of Client Refusal form and the Provider Documentation of Refusal form located on page 3-21)</i></p>



# Example forms for Other Follow Up

## Report of Women Deemed Lost to Follow Up

**Every Woman Matters**  
 Reasonable accommodations made for persons with disabilities  
 TDD (800) 532-2227  
 Version: August 2008

Call us if you have questions  
 (800) 532-2227

1. Client only lost to follow up if you cannot locate her. If you know where she is the client is not lost.  
 Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ (Date provider deemed client was lost to follow up)  
 Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ (Date form completed)

Provider Name, Clinic Name and City: \_\_\_\_\_  
 Client's Name: \_\_\_\_\_  
 Client's Social Security #: \_\_\_\_\_ Client's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

**The client is considered lost to follow up when:**  
 1. Connected by phone and the phone is disconnected.  
 2. Current residence of last known address states that they do not know of such a person or the client no longer lives at the last known address.  
 3. A letter is sent to the client and returns with "client moved no forwarding address given" or "forwarding has expired."

Contact Date	Type of Contact	Results	Leads
1. _____			
2. _____			
3. _____			

1. You must make at least three (3) attempts to locate the client before deeming her lost to follow up. Documentation must include the date and type of contact, as well as the results of the contact. Once a provider has exhausted all conventional means to contact a client to return for follow up, the client can be deemed lost to follow up. Failure to show up for a scheduled appointment does not constitute lost to follow up.

Ready for this project were provided through the Centers for Disease Control and Prevention Budget and Control Policy Division Program, Well Integrated Screening and Evaluation for Human Assets the Value, and Cultural Change Learning Demonstrations Program, Cooperative Agreement with the National Department of Health and Human Services, Division of Field Operations, 40122-0001, 40122-0001, and 40122-0001.

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**Client Informed Refusal**  
 Directions for form:  
 1. Client must fill out Section 1.  
 2. Providers must fill out Section 2 or 3, and all gray shaded areas.

**Section 1:**  
 Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 I, \_\_\_\_\_, have been informed by my healthcare provider, that I should have this test/treatment below. This test/treatment is: \_\_\_\_\_  
 (Please print or type name, the name of the test/treatment and why it is being done)  
 If I do not get this test/treatment I know these things may happen to me: \_\_\_\_\_  
 (Please print or type name, what you will happen if the test/treatment is not done)

I have had the need for this test/treatment explained to me.  
 I know that not having this test/treatment at this time, is against my healthcare provider's advice and may be harmful to my health. My healthcare provider has explained the conditions, including cancer.  
 I know what this test/treatment is for. I know why I need it. I know how it is done.  
 I know that signing this form does not stop me from having the test/treatment done later.  
 I know how to get money to help pay for the test/treatment.  
 I know that I can still get care from Every Woman Matters (EWM) if I do not have this test/treatment.  
 I know that I can supply to EWM if I am a female under 40 years of age.  
 I know that I can supply to EWM if I am a female under 40 years of age.  
 I know that I can supply to EWM if I am a female under 40 years of age.  
 I have read all the information above and know what it means. I am choosing to refuse the above test/treatment at this time.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Section 2:**  
 Submitted by: ☐ Clinic Outreach Worker ☐ Case Manager  
 Facility/Clinic/Agency Information - clinician name, clinic name, city name (do not abbreviate)  
 Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Section 3:**  
 Written by: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Interpreted by: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Portion below to be completed ONLY if client unable to write or has language barrier:**  
 If client unable to write information herself, the client will dictate the information and the form should be witnessed by two individuals.  
 Dictated by: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Written by: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Witnessed by: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Interpreted by: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Complete reverse side only (unable to obtain a signed Client Informed Refusal)

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**Service Provider Documentation**  
 Directions for form:  
 1. Client must fill out Section 1.  
 2. Providers must fill out Section 2 or 3, and all gray shaded areas.

**Section 1:**  
 Provider has informed that the client has enough information to make an informed decision.  
 Client Informed Refusal given to client: ☐ Yes ☐ No on Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Client Informed Refusal given to client by: ☐ Personal Contact / In the Office  
☐ Phone Contact  
☐ Postal Contact

☐ Client returned Client Informed Refusal incomplete.  
☐ Client failed to return a signed Client Informed Refusal.

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Facility/Clinic/Agency Information - clinician name, clinic name, city name (do not abbreviate)  
 Attempts were made to give information to the client regarding:  
☐ Diagnostic Services ☐ Diagnosis  
☐ Treatment Services ☐ Treatment

Provider is unsure of the client or is able to make an informed decision due to one or more of the following reason(s):  
☐ No verbal communication with client ☐ Low literacy level  
☐ Language / Translation issues ☐ Mental / Emotional disability  
☐ Visual / Hearing impairment

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Facility/Clinic/Agency Information - clinician name, clinic name, city name (do not abbreviate)  
 Name of Person completing this form: \_\_\_\_\_  
 Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Facility/Clinic/Agency Information - clinician name, clinic name, city name (do not abbreviate)

National Department of Health and Human Services - Office of Women's and Men's Health  
 Every Woman Matters - 301 Commercial Mall North, P.O. Box 94117 - Lincoln, NE 68509-4117  
 1-800-532-2227 - Fax: (402) 471-0913  
 E-mail: ewm@cdc.gov; ewm@hhs.gov; ewm@hhs.gov; ewm@hhs.gov  
 Ready for this project were provided through the Centers for Disease Control and Prevention Budget and Control Policy Division Program, Well Integrated Screening and Evaluation for Human Assets the Value, and Cultural Change Learning Demonstrations Program, Cooperative Agreement with the National Department of Health and Human Services, Division of Field Operations, 40122-0001, 40122-0001, and 40122-0001.

## Client Informed Refusal and Service Provider Documentation